

**POLICY AND PROCEDURES FOR  
ENDORSEMENT OF PROVIDERS OF Medicaid  
Reimbursable MH-DD-SA Services**

**North Carolina  
Department of Health and Human Services**

**Effective October 1, 2007**

## **I. Purpose and Overview**

### **Purpose:**

The purpose of the review of qualifications and the endorsement of Medicaid Providers is to assure that individuals receive services and supports from organizations that comply with State and Federal laws and regulations and provide services in a manner consistent with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) State Reform Plan. The endorsement process provides the Area Authority/county Program (from this point forward referred to as the Endorsing Agency) with objective criteria to determine the competency and quality of Medicaid Providers. This process does not apply to ICF/MR facilities, hospitals, independent practice settings or groups. Hospitals requesting to provide a service or services are subject to the endorsement process for these services. Providers seeking endorsement must be legally constituted entities capable of meeting all of the requirements of the Standard Agreement and service definitions including accreditation if applicable.

### **Overview:**

For Medicaid-covered MH/DD/SA services as delineated in Clinical Coverage Policy 8A and hereinafter referred to as Community Intervention Services, providers must be endorsed by an Endorsing Agency in order to enroll with the Division of Medical Assistance (DMA) as a Medicaid Provider of an Enhanced Benefit service or services. Endorsement is a verification and quality assurance process using statewide criteria and procedures based on the NC Commission on Mental Health, Developmental Disability, and Substance Abuse Services Rules for Requirements for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services (10A NCAC 26G) that are currently in draft form.

### **Framework for Establishing Provider Qualifications:**

The Secretary of DHHS has rulemaking authority for Provider Endorsement of Community Intervention Service Agencies and CAP-MR/DD providers. Rules regarding Requirements of Endorsement of Providers of Medicaid Reimbursable Mental Health, Developmental Disabilities and Substance Abuse Services, 10A NCAC 26C.0700 thru 10A NCAC 26C .0710) have been codified by the Secretary of the DHHS. These regulations will include the requirement for endorsing organizations to provide a specific service or services as a Provider of MH/DD/SA Medicaid services.

These Policies and Procedures are to be used by all Area Authorities/County Programs (excluding Piedmont). If national accreditation bodies require Area Authorities/County Programs to apply additional requirements to this process, those additional standards shall be required for that Area Authority/County Programs interpretation of these Policies and Procedures shall reside with the DMH/DD/SA.

Provider organizations that wish to provide and seek reimbursement for Medicaid covered Community Intervention Services must enroll directly with the DMA and are subject to Area Authority/County Program (Endorsing Agency) endorsement. Endorsement is a prerequisite for enrollment with DMA and consists of two parts: business verification and site/service<sup>1</sup> approval. The business verification information is submitted to the Endorsing Agency where the provider's NC business office is located. Business review for this provider will be done by that Endorsing Agency.

A provider organization seeking enrollment in the North Carolina Medicaid program as an In-State or Border Provider of MH/DD/SA services to consumers from North Carolina, whose physical location is within the limits established by the Division of Medical Assistance, for treating an out-of-state provider as in-state for the purposes of Medicaid billing, shall meet the requirements for endorsement as set forth in this policy. In this case a provider who has a business office outside of N.C., the business verification will be conducted by the Endorsing Agency receiving the initial application for endorsement. A provider must also seek endorsement in the catchment area in which they intend to deliver service and for the particular service they intend to provide.

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<sup>1</sup> A site is a physical location where a service occurs, records are kept or supervision occurs.

Endorsement and Medicaid enrollment is site and service specific and shall be honored by all Endorsing Agencies. Should a provider that is endorsed by one Endorsing Agency seek to provide services to consumers of other Endorsing Agencies, those other Endorsing Agencies shall verify that the provider's endorsement is current and valid before entry into the Standard Agreement and making referrals to said provider. Endorsed providers will be subject to a review for re-endorsement by the Endorsing Agency on a triennial basis.

## **II. POLICY AND PROCEDURES FOR ENDORSEMENT OF PROVIDERS OF COMMUNITY INTERVENTION SERVICES**

### **Scope:**

- These policies and procedures are applicable to each provider who seeks to provide any of the services as set forth in the Division of Medical Assistance (DMA) Program Specific Clinical Coverage Policies, including subsequent amendments and editions and services under the CAP MR-DD waiver as approved by the Centers for Medicare and Medicaid Services.
- The Secretary may designate an LME for exemption from the endorsement rules.
- This policy will be applied to LME's who have an approved waiver from the Secretary to provide Medicaid services.

### **Policy for Endorsement of Qualified Providers:**

Area Authority/County Programs (Endorsing Agencies) are required to follow policies and procedures specified in this document to ensure statewide consistency of endorsement. If the Endorsing Agency fails to follow the policy as prescribed, provider organizations may initiate an appeal process of the alleged breach. (see Appeals, Section 10)

As previously stated, endorsement is a process of qualifying a provider to provide a specific Medicaid covered MH/DD/SA service or services. When a provider wishes to provide services additional to those for which the provider has a current endorsement, the provider must complete the DMA Addendum for Current CIS Providers to add additional service or services and receive in writing, endorsement for the additional service (**prior to being able to bill directly for that service**). The responsibility resides with the provider to initiate the request for endorsement for the new service. If the endorsement is for a provider that is part of a multi-site provider entity, (i.e. a provider organization with multiple service sites and/or providing multiple services) and the larger entity is already endorsed by another Endorsing Agency, the Endorsing Agency should only verify the currency of the endorsement by the other Endorsing Agency, and then shall only review components of the endorsement checklist which are site-specific or service specific and have not been previously reviewed.

The endorsement process includes:

#### **1. Application for Endorsement**

Services may not be authorized until the provider is endorsed by the Endorsing Agency and enrolled as a Directly Enrolled provider with the Division of Medical Assistance to provide Medicaid MH/DD/SA services (Community Intervention Services). **An endorsed provider MUST be directly enrolled by DMA prior to delivering and billing covered Medicaid services.**

The provider organization shall submit to the Endorsing Agency a correct and complete Division of Medical Assistance Community Intervention Services Provider Enrollment Package. This package shall serve as the application for endorsement with the Endorsing Agency **and** as the complete Provider

Enrollment Package with the Division of Medical Assistance. The business entity of the provider organization shall comply with 10A NCAC 27G .0201. The business entity shall submit a completed Core Rules Self-Study (checklists), with supporting documentation to the Endorsing Agency as a part of the Provider Enrollment Package/application for endorsement.

**The self-study is NOT required if:**

1. The business entity is accredited by an accrediting agency approved by the Secretary as set forth in 10A NCAC 27G .0211
2. At least one MH-DD-SAS service offered by the provider organization is provided in a facility licensed in accordance with G.S. 122C
3. At least one of the services already offered by the provider organization is licensed under G.S. 131 D and an Endorsing Agency has conducted a review within the last twelve months and determined the provider organization is in compliance with the requirements of the core rules; or
4. The Endorsing Agency or a contract agency of the Endorsing Agency has conducted a review within the last twelve months and determined the provider organization is in compliance with the requirements of the core rules, or an equivalent review by a like entity.

The Division of Medical Assistance Community Intervention Services Provider Enrollment Package must be submitted with return receipt/certified mail to the Endorsing Agency in which the provider organization's service is located.

The Endorsing Agency shall evaluate the information submitted in the Provider Enrollment Package for correctness and completeness and notify the provider organization within 20 business days, using return receipt/certified mail, whether the information submitted is correct and complete or whether the business entity is required to make additional submissions in order for the Provider Enrollment Package to be complete.

If additional information is needed the provider will have 5 business days to submit the needed materials to the Endorsing Agency (using return receipt/certified mail). Upon receipt of the needed materials the Endorsing Agency will evaluate for correctness and completeness. If the required information is not received within the 5 business day timeline and the provider wants to continue with the endorsement process the Endorsing Agency will return all documents to the provider and the provider must resubmit the entire application packet and restart the process. If the process is restarted by resubmission of the Provider Enrollment Package the provider organization's position in the schedule for on-site review may be affected (i.e., the Endorsing Agency may have to assign a new date for Provider Enrollment Package submission based on current resource availability). If the 5 business day timeline is met the Endorsing Agency shall notify the provider within 2 business days (using return receipt/certified mail) that the packet is correct and complete.

The Endorsing Agency shall schedule and conduct an on-site review within 20 business days of the receipt of the correct and complete Division of Medical Assistance Community Intervention Services Provider Enrollment Package.

**Business Entity Verification**

A provider organization applying for endorsement is subject to review of business information by the Endorsing Agency. The business information shall be submitted by the provider organization to the Endorsing Agency. This information is the business information included in the Division of Medical Assistance Community Intervention Services Provider Enrollment Package. The provider organization shall also submit to the Endorsing Agency documentation that the business entity is currently registered with the local municipality **or** the office of the NC Secretary of State, that the information registered with the local municipality **or** the Secretary of State is current, and that there are no dissolution, revocation or revenue suspension findings currently attached to the provider entity. The business entity may receive business review either by the Endorsing Agency where the business entity is located, or by the Endorsing

Agency where the first endorsement/ Provider Enrollment Package is submitted, if the business entity is not located in that catchment area.

The business verification shall be conducted by only one Endorsing Agency, even if the business entity has service sites in more than one Endorsing Agency catchment area. Upon receipt of the Provider Enrollment Package for business verification, the Endorsing agency must review the submitted information against businesses registered with the local municipalities and or provider organizations and/or the list of corporations registered with the North Carolina Secretary of State as corporations, and to verify the name, business status, and address of the provider organization and check data from DHHS concerning violations and actions against the provider organization. Business verification status is valid for the duration of three years.

When three years has elapsed, the provider organization shall submit to the Endorsing Agency a copy of the National Accreditation Certificate and a letter of attestation that includes the current business information (name, business status, and address), and any dissolutions, revocations, or revenue suspensions that have occurred over the past 3 years, (using return receipt/certified mail). The Endorsing Agency shall review the information submitted and review any adverse actions, sanction activity and monitoring results. The Endorsing Agency shall retain the right to conduct an onsite review based on the information contained in the letter of attestation. If the information submitted meets endorsement requirements the Endorsing Agency shall renew the Standard Agreement with the provider organization for three more years. If at any time the provider organization's National Accreditation status lapses or is withdrawn the provider organization must notify the Endorsing Agency. Loss of National Accreditation shall lead to withdrawal of provider endorsement.

## **2. On-Site Endorsement Review**

An on-site endorsement review will be performed by the Endorsing Agency within 20 business days of verification of the correct and complete Provider Enrollment Package. The on-site review shall include each service the provider organization seeks to provide, at each site where the provider seeks to provide a service. The Endorsing Agency will use the standardized Endorsement Checklists during the on-site review. The on-site review includes the following elements:

- Provider organization requirements
- Staffing requirements
- Service type/setting requirements
- Clinical requirements
- Documentation requirements

If in the course of the on-site review the Endorsing Agency discovers areas of concern that if substantiated by the Division of Health Services Regulation would result in a Type A violation and affect the status of the current license, the LME shall refer the situation to the Division of Health Services Regulation and suspend the endorsement process. The Endorsing Agency must notify the Division of Health Service Regulation within 24 hours of the on-site visit of the areas of concern. The endorsement process shall be suspended until the Division of Health Services Regulation is satisfied that the provider organization currently meets all licensure requirements and so notifies the Endorsing Agency.

The Endorsing Agency will notify the provider organization by letter, (using return receipt/certified mail), within 10 business days following the on-site review regarding the status of the endorsement review. The notification letter shall specify one of the following actions:

- A. Approved or denied, or
- B. Pended, a plan of correction is required, or,
- C. The findings from the on-site review have been referred to the Division of Health Service Regulation for follow-up.

If the status of the endorsement review is "Pended, a plan of correction is required" because the provider organization is unsuccessful in meeting the requirements for endorsement, the notification letter (referenced above) must be submitted (with return receipt).

### 3. Provider Failure to Meet Requirements

If the status of the endorsement review is “Pended”, a plan of correction is required. The provider will be required to submit a plan of correction per the *DMH/DD/SAS Policy and Procedure for the Review , Approval and Follow-up of Plan(s) of Correction (POC)*. The Endorsing Agency and the provider organization shall follow the process and timelines as indicated in the DMH/DD/SAS Policy and Procedure for the Review , Approval and Follow-up of Plan(s) of Correction (POC). This policy is located on the DMH/DD/SAS website; [www.ncdhhs.gov/mhddsas](http://www.ncdhhs.gov/mhddsas)

If a provider fails to meet business verification requirements, the Provider Enrollment Package is denied and the provider organization will be notified by the Endorsing Agency (using return receipt/certified mail), and (copied to the DMH-DD-SAS), that the provider organization must wait six months before re-applying for business verification with any Endorsing Agency. A provider organization that achieves business verification but fails to meet site/service specific requirements must wait six (6) months to re-apply for services with the Endorsing Agency that denied the site/service endorsement. The provider organization may, however, apply for site/service endorsement through another Endorsing Agency at anytime. If the provider organization determines that they will re-apply, the provider organization must initiate the endorsement process by submitting the complete Provider Enrollment Package to the Endorsing Agency.

If at any time there are any outstanding or unresolved actions from any LME monitoring, Medicaid program compliance monitoring and/or integrity investigative review, or DMH/DD/SAS compliance monitoring and/or investigation, the Endorsing Agency may terminate the endorsement process and/or the Medicaid agency may terminate provider participation in the Medicaid Program

### 4. Letter of Endorsement

When a provider organization is determined to have met endorsement requirements, the Endorsing Agency shall send (using return receipt/certified mail) the provider organization the Standard Agreement for signature. The provider organization has 15 business days to return the signed Standard Agreement. Upon receipt of the signed Standard Agreement, the Endorsing Agency will notify the provider organization of the status of their endorsement, utilizing the standard “Notification of Endorsement Action” (NEA) letter and copy the DMH/DD/SAS, Accountability Team, via electronic submission. The letter will indicate the beginning and expiration date of the endorsement. **An endorsed provider MUST be Directly Enrolled by DMA prior to delivering and billing Medicaid-covered services.**

When a provider organization receives endorsement, they must submit to DMA’s Provider Enrollment Section: the NEA letter, a copy of licensure if applicable and the correct and complete Division of Medical Assistance Community Intervention Services Provider Enrollment Package.

### 5. Denial of Endorsement

**A provider's application for endorsement may be denied for the following reasons:**

- **The provider fails to comply with endorsement requirements. The provider is found to not meet all applicable requirements of Medicaid policy and regulations, federal and state licensure and certification requirements for the type service applied, or that it has employed or contracted with individuals or entities that have been excluded from participating in Medicaid or other federal programs.**
- **The provider has relationships with excluded/debarred individuals or entities. An endorsement application shall be denied if an owner, managing employee, authorized official, medical director, supervising physician or other individuals are excluded from Medicaid participation of other federal health care programs or if debarred from federal procurement. A denial may be reversed if the provider submits documentation that the relationship with the excluded or debarred individual or entity has been terminated within 30 days of the notice of denial.**

- **The provider entity or any of its owners have felony convictions determined to be detrimental to the best interests of the program. A denial may be reversed if the provider submits documentation that the relationship with the convicted individual has been terminated within 30 days of the notice of denial.**
- **The information provided during the application process was false or misleading such that disclosing that information would have resulted in an endorsement denial.**
- **On the basis of an on-site review, it is determined that the provider is not equipped to provide the services for which application for endorsement was made or the provider does not have available the professionals required to provide or supervise treatment.**
- **The applicant has not obtained the required state and local licenses, permits or authorizations (includes professional licenses and facility licenses) to perform the services it intends to provide.**
- **The applicant does not have the physical address where services can be provided, does not have a place where client records can be stored in accordance with HIPAA requirements or does not meet other requirements necessary to do business.**

**The provider will be notified that endorsement has been denied via the standard “Notification of Endorsement Action” letter. The basis for the denial of endorsement that is noted on the Notification of Endorsement Action letter shall be consistent with the reasons noted in this policy. The notice/letter will be signed by the Endorsing Agency CEO and copied to the DMH/DD/SAS.**

## **6. Withdrawal of Endorsement**

Withdrawal of endorsement may be initiated by the Endorsing Agency, DMH/DD/SAS, the Secretary or the endorsed provider organization. If the provider organization is in “Good Standing” with the Endorsing Agency at the time of the initiation of the withdrawal action, withdrawal initiated by the endorsed provider organization is considered and shall be identified as a voluntary withdrawal along with a brief description of the reason for withdrawal. “Good standing” means the endorsed provider organization is in substantial compliance with the requirements of endorsement as set forth in the rule (10A NCAC 26C .0709) for the site and service for which the withdrawal of endorsement is being initiated.

If the endorsed provider is withdrawing endorsement of only one service and will continue to maintain endorsement for other services from the provider organization, the Endorsing Agency will amend the Standard Agreement and issue the “Notification of Endorsement Action” letter to the provider.

**Involuntary withdrawal of endorsement may be initiated by the Endorsing Agency when:**

- The provider organization no longer meets the requirements identified on the service specific check sheets; or
- There are any outstanding or unresolved actions from any LME monitoring, Medicaid program compliance monitoring, integrity investigative review, and/or DMH/DD/SAS compliance monitoring and/or investigation the Endorsing Agency may terminate the endorsement process and/or the Division of Medical Assistance may terminate provider participation in the Medicaid Program; or
- Information submitted regarding business verification is substantially inaccurate; or
- The provider organization’s National Accreditation status lapses or is withdrawn; or

- Licensure is not current; or
- Failure to comply with any provisions of the Standard Agreement; i.e. failure to maintain insurance coverage; or
- The provider fails to meet other conditions of participation with the Division of Medical Assistance; or
- The provider has not removed the cause of a summary suspension of Division of Health Service Regulation licensure within the specified time frame; or
- There is evidence of substantial failure on the provider's part to comply with current rules, including 10 NCAC 26C .0502, or Statutes which apply to the provider agency or endorsed services as determined by the Endorsing Agency during an onsite endorsement review. "Substantial failure to comply" means evidence of one or more of the following:
  - The provider has not addressed issues that endanger the health, safety or welfare of the individuals receiving services; or
  - The provider has been convicted of a crime specified in G. S. 122C – 80;
  - The provider has not made available and accessible all sources of information necessary to complete the monitoring processes set out in G.S. 122-C – 112.1;
  - The provider has created or altered documents to avoid sanctions; or
  - The provider has not submitted, revised or implemented a plan of correction in the specified time frames; or
  - The provider has not removed the cause of a summary suspension within the specified time frame; or

In cases of substantial failure to comply with current rules (as noted in 10A NCAC 26C .0502), the provider's Standard Agreement may be withdrawn by the Endorsing Agency and all other Endorsing Agencies will be notified by DMH/DD/SAS if applicable.

The provider will be notified of the intent to withdraw endorsement via the standard "Notification of Endorsement Action" letter. The basis for the withdrawal of endorsement that is noted on the Notification of Endorsement Action letter shall be consistent with the reasons noted in this policy. The notice/letter will be signed by the Endorsing Agency CEO and copied to the DMH/DD/SAS. The DMH/DD/SAS will issue a recommendation to the DMA to disenroll the provider organization. If it is a licensable service, the DMH/DD/SAS will copy the letter to the Division of Health Service Regulation.

If the Endorsing Agency is withdrawing endorsement of only one service and will continue to maintain endorsement for other services from the provider, the Endorsing Agency will amend the Standard Agreement and issue the "Notification of Endorsement Action" letter to the provider. If the withdrawal of endorsement is initiated by the Endorsing Agency because the endorsed provider organization is not in substantial compliance with requirements for endorsement, the withdrawal of endorsement is considered involuntary withdrawal.

In the case of a withdrawal of business verification, DMH-DD-SAS shall also determine any other site/service specific endorsements which are affected by the withdrawal of the business verification. Such a withdrawal would also prevent the provider agency from being endorsed for any MH-DD-SAS Medicaid service.

If the provider organization's business verification has been withdrawn there will be a waiting period of six (6) months before the provider organization can request business verification from any Endorsing Agency.

If a site/service endorsement is withdrawn, there will be a six (6) month waiting period before the provider organization can reapply for site/service endorsement with the Endorsing Agency that withdrew the endorsement.

The active date of Medicaid payment will stop when the DMA disenrolls the provider organization. In the event of endorsement withdrawal, the LME is responsible for ensuring that the provider organization provides adequate transition of services to an endorsed provider per the consumer's choice.

The DMA will provide the DMH/DD/SAS with information regarding any suspensions, terminations or disenrollment actions taken with any Medicaid enrolled provider of MH/DD/SAS services.

## **7. Agreement**

The Endorsing Agency will enter into a Standard Agreement with an endorsed provider organization. The Standard Agreement and Operations Manual contain the information and materials, such as uniform forms, provisions, and statewide requirements for all endorsed Medicaid Providers.

## **8. Reconsideration and Appeal Rights of the Provider**

A provider whose endorsement status is denied or withdrawn by an Endorsing Agency must first request a local reconsideration of the decision by the Endorsing Agency prior to filing an appeal to the state.

The request for local reconsideration shall be made in writing and sent by certified mail to the Chief Executive Officer (CEO) of the Endorsing Agency within 15 business days from the receipt of the Notification of Endorsement Action letter. The request shall contain a brief statement of the basis upon which the Endorsing Agency's decision is being challenged.

The decision of the Endorsing Agency shall be considered final if a local reconsideration request is not received by the Endorsing Agency within 15 business days after the provider receives the Notification of Endorsement Action letter or if the provider withdraws request for reconsideration.

The Endorsing Agency shall respond to the provider's request for reconsideration of the endorsement denial or withdrawal of endorsement and make a local reconsideration decision within 15 business days from the receipt of the provider's reconsideration request. The reconsideration decision made by the Endorsing Agency must be in writing and sent to the provider by certified mail.

If the provider does not accept the local reconsideration decision, the provider may appeal in writing to the DMH/DD/SAS Provider Endorsement Appeal Panel by certified mail within 15 business days from the receipt of the local reconsideration decision from the Endorsing Agency. The request shall contain a brief statement of the basis upon which the Endorsing Agency's decision is being challenged. Endorsement application, notification of endorsement denial/withdrawal and supplemental documentation to support the provider's case shall be submitted with the appeal request. The provider has the burden of proof. An administrative review of submitted documentation will be completed by the Provider Endorsement Appeal Panel. The supplemental documentation submitted should be information that was presented and available to the Endorsing Agency at the time of their review/decision to deny or withdraw endorsement.

The provider may also appeal the Endorsing Agency's local reconsideration decision directly to the Office of Administrative Hearings (OAH) instead of appealing to the DMH/DD/SAS Provider Endorsement Appeal Panel. The provider must make a written appeal request to OAH by certified mail within 60 business days of the receipt of the administrative review decision.

A provider organization is eligible to initiate an appeal to the DMH/DD/SAS Provider Endorsement Appeal Panel for any one of the following reasons:

- (1) The Endorsing Agency upholds its decision to deny or withdraw endorsement during the reconsideration process; or

- (2) The Endorsing Agency has utilized criteria to deny endorsement that are inconsistent with the DMH/DD/SAS provider endorsement policy and procedures; or
- (3) The Endorsing Agency fails to complete the endorsement review process within the designated timeframes

If the Provider does not accept the decision of the DMH/DD/SAS Provider Endorsement Appeal Panel after the completion of the administrative review, the Provider must make a written request by certified mail for a DMH/DD/SAS informal hearing within 15 business days of the receipt of the administrative review decision. The Provider may submit additional supplemental documentation to support their case with the written informal hearing request. The supplemental documentation submitted should be the information that was presented and available to the Endorsing Agency at the time of their review/decision to deny or withdraw endorsement. Supplemental documentation will not be accepted on the date of the informal hearing. The Provider Endorsement Appeal Panel will conduct the informal hearing. Both the Provider and the Endorsing Agency involved in the endorsement review process shall attend and present at the informal hearing. The Provider has the burden of proof

If the Provider does not accept the informal hearing decision, the Provider may submit a written appeal request to the Office of Administrative Hearings (OAH) by certified mail within 60 business days of receipt of the Division of MH-DD-SAS informal hearing decision.

The Provider may also appeal the Provider Endorsement Appeal Panel's administrative review decision directly to the Office of Administrative Hearings (OAH) instead of requesting an informal hearing. The Provider must make a written appeal request to OAH by certified mail within 60 business days of the receipt of the administrative review decision.

If a **new** Provider who has never been directly enrolled with DMA has an appeal concerning an endorsement that was not granted, the Provider may not bill for services until the appeal is resolved.

For any directly enrolled Medicaid Provider who appeals a withdrawal of an endorsement, or an endorsement that was not renewed by the Endorsing Agency, direct billing of that Medicaid service will be suspended until resolution of the appeal has been made.

## **9. Endorsement of Providers within 40 Miles of North Carolina**

A provider organization seeking enrollment in the North Carolina Medicaid program as an In-State or Border Provider of MH-DD-SA services to consumers from North Carolina, (whose physical location is within the limits established by the Division of Medical Assistance, for treating an out-of-state provider as in-state for the purposes of Medicaid billing), shall meet the requirements for endorsement as set forth in this section. An out-of-state provider organization shall apply for endorsement with an Endorsing Agency per the stated policy. The Endorsing Agency shall be an LME whose catchment area is contiguous with the county or catchment area of the out-of-state provider, or one that has a consumer that has selected the out-of-state provider organization as his or her choice of provider. Upon receipt of the Provider Enrollment Package for business review from the out-of-state provider organization, the Endorsing Agency shall review the submitted information against the list of corporations registered with the state where the out-of-state provider is located and verify the name, business status, and address of the provider organization.

A provider organization applying for endorsement of a service that would require facility licensure if the provider organization were located in North Carolina, must meet the health, safety and building requirements established for provider organizations of an equivalent service in the state the provider organization is located. The Endorsing Agency shall contact the oversight agency in the state the provider organization is located to determine if the provider organization meets the requirements.

## **10. CAP-MR/DD:**

- o Endorsement for waiver services is site and service specific.

- Site means a location where a service occurs, records are kept, or supervision occurs. **There is no requirement that a provider establish a site in every LME catchment area, however, it is expected that supervision and oversight is available in reasonable proximity to where services are delivered.**
- The specific site must be reviewed for the services the provider requests to provide per the provider endorsement policy.
- If the provider does not meet the requirements of the service definition check sheet for that site and the specific services reviewed the LME will be expected to follow the provider endorsement policy.
- The LME must notify the provider at the local office/site, as well as the business office, in writing of any withdrawal of a site/service. In addition, the LME must notify DMA via an NEA letter directly and immediately if a CAP-MR/DD provider has endorsement withdrawn at any site for any services.
- Verification that the provider has discontinued service and billing for the service at the specific site will occur through post payment review and monitoring processes.
- If a currently enrolled CAP-MR/DD provider wishes to add a new waiver service, the provider must be reviewed per the endorsement policy in effect at the time of the endorsement review. In addition, the provider must attach a copy of any appropriate licenses to the appropriate service definition check sheet. For any unlicensed AFL(s) a health and safety review using the check sheet developed by the DMH/DD/SAS must be completed in lieu of a license.
- Any time an already enrolled Residential Support provider desires to open a new AFL site the provider must notify the LME of the AFL site and the LME must complete a health and safety review for that particular home. It is not required that the already enrolled provider be reviewed against the Residential Supports check sheet again for that AFL site. The check sheet is a requirement only for a provider who has never been endorsed to provide Residential Supports.
- Although Enhanced Personal Care and Enhanced Respite have distinct billing codes they are not separate services that require endorsement. Providers enrolled to provide Personal Care and Respite are also enrolled to provide the enhanced level of these services. It should be noted, however, that there is a clear expectation that staff providing the enhanced level of service have specified training requirements identified in the Plan of Care that would require the enhanced level.

## 11. Process for LME Endorsement

LME(s) that wish to provide and seek reimbursement for Medicaid Community Intervention Services must request and receive a waiver from the Secretary's Waiver Board to provide direct services. LMEs will only be considered for a waiver to provide direct service if there is evidence that community capacity is inadequate in the catchment area for that given service and the LME is working aggressively to recruit and maintain adequate provider capacity. An LME plan indicating service needs, gaps, and possible strategies to assure adequate community capacity will be considered as evidence.

The LME must be directly enrolled with the DMA and is subject to the Provider Endorsement Process by DHHS. DMH/DD/SA will review applications and conduct onsite reviews of LME services for endorsement. LME endorsement will only be granted on a temporary basis, as specified in the LME waiver.

Prior to the expiration of the waiver, the LME must request an extension to the waiver to continue to provide services. The LME must justify the continuance of providing the service by submitting a letter to the DMH LME Team Leader with justification for the need to continue to provide the service and a brief description of attempts to build community capacity. The Secretary's Waiver Board will review and determine if the extension to the waiver is justified and approved.

The endorsement process is initiated by the submission of an application from the LME that contains site/service specific information for each service definition.

### **Scope**

This policy applies to all LMEs (excluding any LME participating in a CMS waiver) that have been approved by the Secretary's Waiver Board to provide Medicaid MH/DD/SA Community Intervention Services.

LMEs are required to follow this process to ensure statewide consistency of endorsement. If an LME fails to follow this process it will not be eligible for Direct Enrollment with DMA for Medicaid MH/DD/SA Community Intervention services.

### **Submission of Application:**

LMEs must electronically submit a correct and complete application to the DMH/DD/SAS LME Systems Performance Team Leader. The Application is Attachment A to this policy. The DMH/DD/SAS will acknowledge receipt of the application by return email to the contact person of the LME within 5 business days. The DMH/DD/SAS will review the application for correctness and completeness of information/materials and notify the LME of needed documents or information within 10 business days of receipt of the application.

If additional information is needed the LME will have 5 business days to submit the needed information to the DMH/DD/SAS. If the needed materials are not submitted to the DMH/DD/SAS by the LME within 5 business days, the DMH/DD/SAS will return the application and the LME must resubmit the entire application packet. All correspondence should be sent via return receipt/certified mail.

### **On-Site Review:**

An onsite endorsement review will be performed by a 2 member team; one member of the LME team and one member of the Best Practice team. The LME Team staff will not review/participate in reviews of LMEs to which they are primarily assigned.

The onsite review will be completed within 20 business days of notification to the LME that the application packet is complete.

The two member review team will use the standardized Endorsement Checklists for the Medicaid MH/DD/SA Community Intervention Service definitions during the onsite review.

### **Letter of Endorsement:**

The DMH/DD/SAS will only grant temporary endorsement to a LME as specified in the LME waiver. Endorsement shall be granted upon meeting the requirements of the onsite review using the service-specific checksheets. Endorsement will be site and service specific.

The DMH/DD/SAS will notify the LME of the status of their endorsement utilizing the standard "Notification of Endorsement Action" (NEA) letter. The letter will indicate the beginning and expiration date of the endorsement.). **The date that DMA APPROVES the Provider Enrollment Package is the earliest possible effective date for both referrals as well as the delivery of Medicaid services.**

When an LME receives endorsement, they must submit to DMA's Provider Enrollment Section: The NEA letter, a copy of licensure if applicable and a completed Re-Enrollment Addendum.

**LME fails to meet requirements:**

If the LME does not meet requirements for endorsement it will have 20 business days to make corrections and submit by email additional documents and/or materials. An abbreviated onsite review may be conducted by the 2 member review team or the documents may only undergo a desk review. The DMH-DD-SAS/Endorsing agency will notify the LME of the status of their endorsement utilizing the standard "Notification of Endorsement Action" (NEA) letter.

**Reconsideration and Appeal Rights for LMEs**

LME's whose endorsement has been denied or withdrawn have appeal rights per DMH/DD/SAS Provider Endorsement Appeal Policy.

The LME whose endorsement status has been denied or withdrawn must first request a written reconsideration of the decision to the DMH/DD/SAS LME Systems Performance Team Leader by certified mail.

If the LME does not agree with the reconsideration decision, the LME may appeal the decision to deny or withdraw the endorsement to the DMH/DD/SAS Accountability Team Provider Endorsement Appeal Panel by certified mail within 15 business days from the receipt of the reconsideration decision.

The appeal request shall contain a brief statement of the basis upon which the review team's decision is being challenged. The endorsement application, notification of endorsement denial/withdrawal and supplemental documentation to support the LME's case shall be submitted with the written appeal request. The LME has the burden of proof.

If the LME does not accept the decision of the DMH/DD/SAS Provider Endorsement Appeal Panel after completion of the administrative review, the LME must make a written request for a DMH/DD/SAS informal hearing by certified mail within 15 business days of the receipt of the administrative review decision. The Provider Endorsement Appeal Panel will also conduct the informal hearing.

Both the LME and the two-member review team involved in the LME's endorsement review process will present at the informal hearing. The LME has the burden of proof. The LME may submit additional supplemental documentation to support the case with the written informal hearing request. The supplemental documentation submitted should be information that was presented and available to the 2 member review team at the time of their review/decision to deny or withdraw endorsement. Supplemental documentation will not be accepted on the date of the informal hearing.

If the LME does not accept the informal hearing decision, the LME may submit a written appeal request to the Office of Administrative Hearings (OAH) by certified mail within 60 business days of receipt of the informal hearing decision.

The LME may also appeal the Provider Endorsement Appeal Panel's administrative review decision directly to the Office of Administrative Hearings (OAH) instead of requesting an informal hearing. The LME must make a written appeal request to OAH by certified mail within 60 business days of the receipt of the administrative review decision.

## DEFINITIONS

As used in this policy the following terms have the meanings specified:

- (1) “Checksheet” means the list of requirements, per each service definition, that shall be met in order to obtain endorsement. (checksheets are available on the MH-DD-SAS website, <http://www.ncdhhs.gov/mhddsas>).
- (2) “Core rules” means those general rules identified in 10A NCAC 27G .0100-.0900, governing Mental Health, Developmental Disabilities and Substance Abuse services, for both facilities and agencies providing such services, and the area programs administering such services within the scope of G.S. 122C. Administrative rules are part of the North Carolina Administrative Code (NCAC) written to fully interpret General Statutes.
- (3) “Business entity” means the business management component of the provider organization. The business entity may be located in the same physical location as the provider organization, or it may be in a different physical location. The business entity may be registered with the local municipality.
- (4) “Business verification” means to confirm the completeness and accuracy of the business entity information as required on the application.
- (5) “Endorsement” means a verification and quality assurance process using statewide criteria and tools set out in this Section to determine the competency and quality of services.
- (6) “Endorsing Agency” means the entity, whether it is the Local Management Entity or Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH-DD-SAS) that has the responsibility to endorse and/or withdraw endorsement of a provider organization for the provision of a service.
- (7) “Legally constituted entity” means a for-profit corporation or nonprofit corporation as defined in G.S. 55-1-40 that is entitled or required to submit filings to the Department of the Secretary of State under G.S. 55D-10 and currently active in good standing in its filings with the Department, or a business entity that is not incorporated but is registered with the local municipality.
- (8) “Local management entity” means the same as defined in G.S. 122C-3(20b).
- (9) “Provider Organization” means the provider agency that is seeking endorsement to provide the service.

- (10) “Site” means the location where a service occurs, records are kept or supervision occurs.
- (11) “Site/service endorsement” means the review and approval of a site to provide a service or services to be delivered at a specific site.
- (12) “Standard Agreement” means the state approved, statewide, signed document outlining expectations and responsibilities between the provider organization and the endorsing Agency, effective for a 3 year period.
- (13) “COMMUNITY INTERVENTION SERVICE [CIS] AGENCY” – Term used as a provider agency classification to confirm that the agency has met the eligibility criteria for entering into a participation agreement with the Division of Medical Assistance to provide certain specific services that have been endorsed or approved by the entity [the LME for MH/DD/SAS] responsible for determining such eligibility. Once approval or endorsement has been awarded, the service provider agency may then achieve approved status as a Medicaid Provider of Community Intervention Services and enter into a participation agreement to provide the services.
- (14) “Business Days” means per the official State business calendar.